

Pediatrics & Parents

The newsletter for people who care for children

Richard J. Sagall, MD, Editor

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Spraying the Nose

Want to help your child get over a cold quicker? Nasal saline spray may be just what you and your child need. That's the result of a study from the Czech Republic. Children that received the nasal spray experienced a faster resolution of their nasal symptoms and fewer recurrences of them than the children that received traditional cold treatment alone.

The 401 children age six to ten years old in the study had uncomplicated cold or flu symptoms. All of the children received standard cold care, but half were also treated with a modified seawater solution nasal wash. (The manufacturer of the seawater solution sponsored the study.)

According to lead researcher Ivo Slapak, MD, of the Pediatric Otorhinolaryngology Clinic, Teaching Hospital Brno, "Children in the saline group showed faster resolution of some nasal symptoms during acute illness and less frequent reappearance of rhinitis subsequently. Results showing reduction in URTIs (upper respiratory tract infections) were robust and consistent in a number of parameters, including rhinologic symptoms, medication consumption, reported illness, school absence, and complication rate. Children showed a higher acceptance for the milder cleansing strength (fine spray)."

Archives of Otolaryngology - Head & Neck Surgery, 1/08

Corticosteroids, Asthma, and Growth

Inhaled corticosteroids – such as Flovent and Pulmicort respules – are the first-line therapy for children with mild, chronic asthma symptoms. Regularly using this type of drug reduces the severity of the symptoms, the number of asthma attacks, and asthma-related deaths. As the success of these drugs have become more evident, their use for children of all ages, even those under age five, has increased. Such widespread use has lead to worry that these drugs may affect the adult height of the children.

In a recently published study that looked at the long-term safety of inhaled ciclesonide on growth, researchers found this relatively new asthma drug had no adverse effect on children's growth. Of the 661 children five to eight and a half years old, half received the medicine (in two different doses) and half a placebo. The growth rates for the two ciclesonide treatments after 12 months were the same as for the placebo.

Lead researcher David P. Skoner, MD and his colleagues concluded that "Ciclesonide demonstrated no detectable effect on childhood growth velocity, even at the highest dosage, which may ease concerns about systemic adverse events."

Pediatrics, 1/08

Inflammatory Bowel Disease

By Sarah Noble

There are dozens of possible causes for children's sometimes ceaseless stomachaches. Anything from stress to the flu could cause pain. It is not uncommon for children to have sensitive stomachs and, most of the time, there is no need to be concerned. However, when your child's sensitive stomach becomes persistent and worsening, it never hurts to contact your pediatrician.

According to Dr. Michael Kappelman, MD, MPH, assistant professor of pediatrics at the University of North Carolina School of Medicine at Chapel Hill, "Inflammatory bowel disease (IBD) affects about 50,000 to 75,000 kids in the United States." IBD is a chronic autoimmune disease that results in inflammation of the gastrointestinal tract.

Dr. Kappelman says that physicians believe, "Most people with IBD have an overactive immune system, in which their intestine mounts an inflammatory response as if it were fighting an infection, even though no infectious organism can be identified. This inflammatory response results in damage to the gastrointestinal tract." The body is seemingly attacking itself.

"Another possibility is that some cases of IBD may be the result of an immune deficiency. Indeed, there are a number of immunodeficiencies that have symptoms that mimic those of IBD, and some new research suggests that therapies that stimulate the immune system might be helpful in treating patients with Crohn's disease," Dr. Kappelman says.

Dr. Kappelman believes IBD involves, "a complex interplay of genetics and environmental exposure. Possible contributing environmental factors may include the presence of disease-causing bacteria, the absence of protective bacteria, and lifestyle." However, a definite cause remains unknown. Although parents may attribute children's stomachaches to food, Dr. Kappelman says "There is no good research to suggest a dietary cause for IBD."

There are two main types of IBD, Crohn's disease and ulcerative colitis. According to Dr. Kappelman, "Crohn's disease is more prevalent in pediatrics." Crohn's disease can affect anywhere in the gastrointestinal tract and consists of deep inflammation through numerous levels of intestinal tissue. "Crohn's disease can also cause fistulas, or internal connections of the intestines to the skin or other organs, as well as strictures, or narrowing of the intestines." Ulcerative colitis, on the

other hand, only affects the colon and consists of inflammation of the more superficial, or external, layers of the intestine.

Although there is no cure for IBD, patients may experience periodic remissions. In general, they experience a continuous cycle of flares and remissions. A flare occurs when there is active disease and symptoms are prevalent. When symptoms are lessened and the patient is healthier, they are said to be in remission. "There is no telling how long a remission period will last, but things, such as adhering to medications prescribed by your doctor can prolong the length of remission, and factors including infections, smoking and overuse of antibiotics, can contribute to flares," Dr. Kappelman says.

Since parents may find it hard to distinguish when IBD may be a possibility, there are a number of red flags to look out for in these situations. Dr. Marsha Kay, a staff pediatric gastroenterologist at Children's Hospital Cleveland Clinic, says "The visibility of these symptoms may vary according to the child's age because older children are more likely to be able to communicate more efficiently to their parents. Common symptoms of IBD include an increased amount of bowel movements for an extended amount of time, fecal urgency, blood in stool, diarrhea, unexplained fevers, stunted growth, swelling of joints, abdominal pain, and skin rashes."

It is important for parents to remain calm and remember that there can be many other reasons for symptoms like diarrhea. According to Dr. Kay, "The key is to look for a significant change in the child, such as waking up at night because of stomach pain or diarrhea."

Growth problems are also common in children with IBD. "This disease often requires children to increase their caloric intake to help fight off the disease because the body is robbing them of calories to fight off inflammation," explains Dr. Kay. However, IBD patients also often experience loss of appetite and nausea, which may make children less likely to eat. These two factors fight against each other, which can result in stunted growth and absorption problems. According to Dr. Kay, "Girls with IBD may also experience a delay in their first period, or, if they have already started menstruating, they may stop."

If a parent suspects there may be a possibility of IBD, Dr. Kay says there are a number of tests they can expect. "The pediatrician may run basic blood tests,

a rectal exam, and stool samples. If there is reason to continue testing, the child will most likely be sent to a pediatric gastroenterologist to proceed with the testing. There the child may undergo an upper endoscopy and or colonoscopy including endoscopic biopsies, CT scans, and a variety of other tests that may also aid in the diagnosis of IBD."

If the child is diagnosed with IBD, the next step is to treat the disease. Since there is no cure for IBD, Dr. Kappelman says, "There are two main goals of treatment: to induce remission and to maintain remission by blocking pathways of inflammation." There are a variety of medications available to help alleviate pain for IBD patients. Dr. Kappelman also says, "Nutritional therapies, which treat the disease activity and promote and health development, are also effective, and becoming more popular in the United States."

Dr. Kay agrees and says, "These treatments involve an elemental, or polymeric, diet, which consists of foods that are very broken down."

There are circumstances in which surgery does become necessary for IBD patients. Dr. Kappelman says, "Surgery is most likely necessary when the patient does not respond to medications or experiences complications from the disease."

According to Dr. Kay, however, "Surgery, especially emergency surgery, has recently become very limited." She believes this is because of new medications such as Remicade and Humira. She says that "Remicade is the biggest advancement in the last ten years of IBD." Dr. Kay adds that "It is a miracle drug that allows patients to do the things they want to do."

Sarah Noble is currently studying journalism at The University of Dayton and actively pursuing a career in freelance writing. She was diagnosed with Crohn's Disease in 2006 and has been fighting it ever since. She has developed a passion for educating others about this familiar, yet serious disease and has joined the fight against chronic illness.

The Crisis of Childhood Obesity: What You Can Do

By Tiffany C. Rush-Wilson, PhD

Childhood and adolescent obesity is a problem that impacts members of all races and socioeconomic groups. There are many mental health, psychosocial, and medical consequences that must be made clear to clinicians, parents, and children who are living with obesity. A definition of childhood obesity, signs and symptoms, medication interventions, and future directions of treatment will be discussed in this article.

Introduction

During the past ten years, obesity in the United States has doubled, and currently one in six children is obese. Due largely to this health crisis, we now have a generation of children with a projected life expectancy that is shorter than that of their parents. In the last two decades, the number of children and teens with obesity (ages two to eighteen) increased nearly 300%, with the number of overweight African-American and Hispanic/Latino children increasing dramatically and disproportionately (nearly one-fourth of children from these groups are overweight). These numbers are of epidemic proportions across racial and ethnic groups in this country.

These disconcerting statistics have inspired a media

influx of information about eating disorders (including anorexia nervosa, bulimia nervosa, and binge eating), healthy choices in food selection, and exercise. Children, parents, and clinicians, as consumers of food and the media, may have difficulty determining what data to accept and what to further investigate.

Contemporary reports highlight traditional approaches to reducing obesity, including diet and exercise, calorie reduction, and the infusion of fresh fruits and vegetables into children's lives. Criticisms of the reduction and elimination of physical education activities in school curricula, as well as the accessibility of sugary and fattening snacks have also been evident, and the media continues to provide balanced accounts of body size. Controversial treatments – such as using medications intended for purposes other than weight loss, and exercise programs that minimize the importance of cardiovascular activity in favor of strength training – have been gaining attention. Such contradictory information can make decision making difficult.

Childhood Obesity

What is obesity? Simply put, obesity is a condition in which a person's weight is more than 20% greater than

is recommended for his or her height and age. Believe it or not, there is no official diagnosis mental health clinicians use to determine the potentially complicated psychological process of overweight in children.

There can be social consequences for children who are overweight. Obese children may endure teasing, difficulties with physical activities, and self-esteem problems related to negative media images. Psychiatric literature about disordered eating has been available in the media and academia for many years. A greater amount of information is now available about how to diagnose, treat, and support children who are overweight.

There is no single cause of obesity. The etiology, or causes, can be complex. Some children's obesity can be traced to medical conditions, chemical sensitivity, or even adrenal gland function. Other causes may be related to psychological, familial, and cultural factors. Modern society places a great deal of emphasis on having an "ideal" body. Marketing ads geared toward children and young adults promote the idea that having a perfect body is associated with having a great life, affluence, an active social life, and many other benefits. Just look at the next toy or music ad and look for the chubby children. They're not there. Children may compare themselves to these images and develop an eating-disordered mentality.

Eating Disorders

There are three primary categories of eating disorders. Anorexia nervosa is a rare syndrome that affects one-half to one percent of the U.S. population of adolescent girls. Symptoms include dramatic weight loss, restrictive eating patterns, and psychological distress. The disorder has been well researched for more than a century. Bulimia nervosa, or the binge-purge syndrome, is more common than anorexia nervosa and affects one to three percent of the adolescent female population in the United States. Although the American Psychiatric Association does not yet officially list Binge Eating Disorder (BED) as an eating disorder, ongoing diagnostic supports this syndrome. People who meet the proposed requirements for BED consume more food and calories than the average person at a sitting and feel guilt about the consumption as well as a lack of control over their eating, but they do not use unhealthy means to get rid of the food. Of the three eating disorders, BED is the

most common. Research has estimated that more than one-half to four percent of the population may have this syndrome. Other estimates are higher. Overweight children, who may feel a lack of control over their eating and eat beyond the point of satiety, thereby consuming more calories at a single sitting than the average adult, can suffer from this psychological condition. This overeating is a serious concern. Excessive weight gain can lead to problems with obesity, premature puberty, diabetes, and other medical complications.

While certainly increasing in prevalence, childhood obesity is not new. As a clinician who treats eating disorders, I have seen serious cases of obesity in children, with two being particularly striking. In the 1970s, there were two children in my second-grade class who had severe problems with obesity. Both of these clients were young girls; one was six years old and the other

was twelve. From these two cases, I learned two important obesity factors. First, the "clean your plate" rule, a well-meaning standard in both of these girls' lives, can be counterproductive. A six-year-old child has different nutritional needs than an adult. This child, at such a young age, weighed 10 pounds more than is recommended for a 5'2" adult woman.

The 12 year old was morbidly obese and used food as a method to self soothe. Her eating practice was ultimately seen as an issue of neglect by social services, and her extreme overweight ultimately became the opening for outside help and support. It was her proverbial cry for help.

Conclusion

So what can you do to help ensure your child is a healthy weight? Here are a few suggestions to get you started.

- If you are concerned about your child's weight, make an appointment with her physician to rule out any physical causes. Discuss your concerns. After a physical examination, your child's physician will be able to make a recommendation about how to proceed. Do not encourage your child to begin a weight modification plan without first consulting a physician.
- Talk to your child about healthy food choices. Help her distinguish between unhealthy popular foods and healthy choices.
- Learn about organic foods. While they are usually

Calculate Your BMI

To calculate your BMI (using English standard measurements), divide your weight in pounds by your height in inches. Use that number and divide it once again by height in inches and then multiply it by 703. A result that is smaller than 18.5 indicates that a person is underweight. A healthy weight range is between BMI scores of 18.5 and 24.9, overweight scores are 25.0–29.9, and obesity scores begin at 30.0.

more expensive than conventional foods, having fewer chemicals in your child's diet can be beneficial.

- Plan out menus together and encourage your child to participate in meal preparation.
- Convenience foods are a necessity in the lives of many busy families. If it is not feasible to eliminate these from your child's diet, consider incorporating fresh fruits and vegetables and salads into mealtime.
- Model healthy eating and exercise behaviors. Children learn from watching the actions of the influential adults in their lives.
- Talk to your child about the reasons we eat – to nourish ourselves – and help her have an awareness of eating for non-hunger reasons.
- Discuss emotional eating with your child. Talk about ways to identify and express emotions that are not related to food.
- Ensure that your child has a trustworthy adult confidant. Often this person is a parent, trusted relative, teacher, someone affiliated with a religious congregation, or the parent of a close friend. Access to a responsible, trustworthy adult will be a tremendous asset to your child's emotional well being.

- Parents, move your body! Dance with your child, go for walks, and engage in physical activities as a family. Unfortunately children and adolescents have less access to physical education and recess than they did a decade ago. The physical activity that they get at home may be a major component of their overall exercise.
- Encourage your child to join extracurricular activities such as sports, which may help improve her self-esteem and physical health.
- Limit the amount of time your child engages in sedentary activities. While television viewing, video games, Internet usage, and other similar activities can be fun and mentally engaging, they do not promote much physical movement.
- Consider doing a charity walk/ run together. These events often have a children's walk/ run event.

Dr. Rush-Wilson conducted her graduate training at John Carroll University (MA) and at the University of Akron (PhD). Her master's independent study was on eating disorders. Her doctoral dissertation was a qualitative study on eating disorders among African-American women. The research generated a theory of why women in this group develop and suffer from these disorders. In addition, Dr. Rush-Wilson recently presented at the She currently runs the Chagrin Counseling Associates and Eating Recovery Center.

Head Growth in Autistic Children

Thanks to increased awareness of autism spectrum disorder, diagnosing autism at an earlier age — as early as age two, instead of age four or later — has become easier. Often, diagnosis is made based on observing and recognizing a child's behavior. Research has also found a correlation between abnormal head circumference growth and autism, with accelerated head circumference growth apparent as early as age one. But, the most recent study of this link has found that head overgrowth may be detected as early as six to nine months of age.

In the study, published in the October 2007 issue of *Journal of Child Neurology*, lead researcher Sara Webb, MD, from the University of Washington Autism Center and her colleagues, used the head circumference measurements of 28 autistic boys and eight developmentally delayed boys to look for abnormal growth. Specifically, they used the head circumference

measurements that were taken for the boys from birth through age 36 months that were charted in their medical records. They found two things: the overall rate of head circumference growth was statically significantly greater for the autistic boys than the developmentally delayed boys during this three-year time frame, and the occipitofrontal circumference measurement was statistically significantly greater at 7-10 months of age for the autistic boys than for the norm.

"We know there are a number of risk factors for autism, and if we can pinpoint them we have better ways of identifying children at risk so we can get them into prevention or monitoring," Webb says. "This abnormal or accelerated rate of head circumference growth is a biological marker for autism. It occurs before the onset of behavioral symptoms at 12 months of age."

Journal of Child Neurology, 10/07



Children in Hospitals

By John E. Monaco, MD

Tommie Ate What?

Tommie is a great kid. His grandmother was determined that we understand this. He is eight years old, is significantly developmentally delayed and attends a special school that he adores. She had taken care of him since birth. The whereabouts of his mother, at least for us, was unknown. When he was first seen one night in the emergency room, he was in severe distress, so there was no way for his medical caretakers to know anything about his usual behavior. All we knew was that he was in shock, his abdomen was distended and he was having trouble breathing.

When the ER doc asked his grandma if Tommie could have gotten into anything that he might have accidentally ingested, she didn't think so. But then she said that occasionally he likes to play with the magnets on the refrigerator, and sometimes she has seen him put these small, attractive items in his mouth. The magnets were the first clue. A simple abdominal X-ray gave the rest of the answer.

Tommie had not only eaten a few refrigerator magnets, but he had also snacked on a veritable smorgasbord of household odds and ends. The X-rays indeed demonstrated the small round magnets embedded in plastic that formerly had been stuck to the refrigerator. (Plastic does not show up well on X-ray.) But along with these items were the unmistakable images of screws, nails and a few of the most concerning items – batteries. (By batteries I mean what are referred to as “button batteries”).

When ER docs see batteries on X-rays of the digestive tract, alarm bells go off in their heads. They know that batteries, through a combination of electrical and chemical properties, can cause erosions in the stomach and intestine if they rest against the wall long enough. Since Tommie was not able to tell anyone when, exactly, he had ingested the offending items, and his grandmother only brought him to the ER when his belly started to bother him, one could only assume that the cause for the pain was the batteries, and they had probably been there a while.

Surgical exploration revealed our worst fears. It was

not the nails, screws or refrigerator magnets that were concerning. Believe it or not, most of these items will pass through the GI tract without causing significant injury. The batteries, and there were only two or three thankfully, had eroded through the wall of the small bowel and had begun eating through the large intestine which, had adhered itself to surrounding structures due to the inflammation caused by the perforated small bowel.

Needless to say, the repair required was extensive. A portion of the small bowel was removed, and the two new ends were attached together. This took place only after the entire length of the large and small intestine was explored for foreign bodies. An X-ray machine was brought into the operating suite so that a final check could be made for the objects. When the bowel was satisfactorily repaired and the surgical team was convinced that all objects were removed, Tommie's abdomen was closed and he was sent to the pediatric ICU for recovery.

His recovery was rocky at first. Whenever there is extensive abdominal surgery, there are tremendous fluid shifts and swelling that can affect blood pressure, blood chemistries and even respiratory status. Tommie needed our help in all these areas, but after a couple days of truly intensive care, he began to turn around. After a couple more days when he was able to get up out of bed and have some of the lines and tubes removed, we began to see what a charming young man he was. In fact, had it not been for the irrefutable surgical proof of all he had ingested, one would have never suspected his gastronomic proclivities. He just looked like a normal eight-year-old kid, sitting there trying to recover from extensive abdominal surgery. It was indeed difficult to picture him as someone, who only days earlier, had reached up, pulled magnets off the refrigerator and popped them in his mouth.

And this points out one of the true challenges of pediatric medicine. It is well known that the art of diagnosis depends very heavily on an accurate history obtained from a reliable patient. When that patient is an eight

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Ask "Baby Doc" Eden

By Alvin N. Eden, MD

Twins

The incidence of twin births has increased dramatically over the last twenty years. The more widespread use of fertility drugs in the treatment of infertility (ovarian stimulating- medications) as well as more and more successful in-vitro fertilizations are the major reasons for this increase. In 1980, before fertility drugs and newer technology were available, the incidence of twins births was about one in sixty, according to the 2005 National Vital Statistics Report from the Centers for Disease Control and Prevention. The current incidence is one in thirty births.

There are two types of twins, identical (monozygotic, one egg) and fraternal (dizygotic, two eggs). There is no genetic influence with identical twins. Fraternal twins run in families, occur more often beyond the second pregnancy and in older women. The current increased incidence of twins is therefore due to the increase in fraternal twins.

Currently, it is estimated that 90% of twins are detected before delivery. Elevated levels of serum alphafetoprotein and human chorionic gonadotropin (HCG) are clues to multiple births, and confirmation is obtained by ultrasound.

At the time of delivery of twins it is not always possible to determine if the twins are identical or fraternal. Even if the placentas are separated the twins are not necessarily fraternal. Further, an apparently single placenta may be present with fraternal twins. Therefore in many cases of twins it will take time to be certain whether or not they are identical. Obviously, if the twins are of different gender, a boy and a girl, they cannot be identical.

If there is some urgency in finding out if the twins are identical, detailed blood typing, DNA fingerprinting and tissue (HCA) typing can be done. But usually there is no rush to know. In a few months the answer will become clear with identical twins. The following is required:

1. Both are the same sex
2. Features, including ears and teeth, must be alike
3. Hair must be identical in color, texture and distribution

4. Eyes are same color
5. Skin of both must be same color and texture
6. Hands and feet must be of similar size
7. Should be very close in height and weight

If you are one out of the thirty mothers who gives birth to twins, the most important thing to remember is that each of your babies, even if he is identical to the other, is a separate, different and distinct human being. The parents of fraternal twins realize this because their twins look different. But often, in my experience, many parents of identical twins don't think of their two look-a-likes as two separate little people.

It is important to remember that each twin grows and develops at his own pace, and he should never be compared to the other.

The reality of being a parent of twins is that you will have twice as much work (as well as twice as much fun as they get older). Some good advice is to try to take care of both twins together whenever possible. For example, try to feed and bathe them at the same time. In some cases you can breastfeed them both at the same time, one on each breast. If this method is successful, it's a good idea to alternate the position of the twins with each feeding, so you don't play favorites. However, keeping track may be difficult.

I once had a breastfeeding mother of twins who solved the problem of position by designating her twin girls A and B and her breasts A and B. She established alternating schedules, either an A and A and B and B feeding or an A and B and B and A feeding. I didn't believe her but she insisted her system was foolproof and worked. In my experience, most mothers cannot follow this simultaneous twin feeding system. If your breast milk supply is not adequate for both babies or if you find it too difficult to breastfeed both during the same feeding period, simply breastfeed one twin and formulafeed the other, again alternating with each feeding. Most mothers of twins find that this combination feeding method works best. My best advice is to accept all the help you can get, especially during the first few months.

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Perspectives on Parenting

By Michael K. Meyerhoff, EdD

Establishing an Appropriate Adaption Level

There is a noteworthy tale from Yiddish literature about a poor, hard-working man from the shtetl (ghetto) who dies and goes to heaven. Upon his arrival at the pearly gates, the angels inform him that since he led a righteous and virtuous life, he is immediately entitled to anything he would like.

"I can have anything?" he asks incredulously.

"Anything," the angels reply. "What would make you happy?"

The man furrows his brow and thinks for a while. Suddenly, his eyes brighten and a smile forms on his face. Still hesitant to fully believe their assurances, he sheepishly inquires, "Can I have a hot roll with butter?"

I love this story because it illustrates a critically important concept in psychology called "adaptation level." In life, items and events in and of themselves do not have the capacity to make us happy or satisfied. It is how we evaluate those items and events. And one of the major standards we employ in this process is the level to which we have become accustomed.

Let's say you are a student who has just received a B on an exam. Are you elated or are you chagrined? Clearly, that depends on your past experience. If you are a struggling student who never received anything higher than a C before, you are ecstatic. On the other hand, if you are a superb student who never received anything lower than an A before, you are miserable.

Now I don't think it is a good idea to sabotage your child's academic performance so she will be content with mediocre grades later on. But I do think parents should think carefully about this concept when it comes to life in general. Is it the job of parents to provide their little one with everything she wants? Or is it simply to establish an appropriate adaptation level?

Unfortunately, I am finding that a lot of modern mothers and fathers are going in the former direction. They seem to find it impossible to say "no" to their children's requests, no matter how expensive or outrageous. And as more and more mothers and fathers join in the trend,

the competition becomes fierce and the stakes get raised to truly ridiculous heights.

I have seen birthday parties for six-year-olds that are as lavish as a royal wedding. I've seen eight-year-olds wearing \$250 sports-logo jackets and \$150 athletic shoes that they will grow out of in a matter of a few short months – necessitating constant repeats of the cash outlay. I've seen 10-year-olds with all sorts of high-tech devices such as cell phones, CD and DVD players, video game stations, etc. that make their bedrooms look like NASA Control. And I've seen parents spend thousands of dollars to purchase Hannah Montana concert tickets for their 12-year-olds.

In all cases, the parents justify what they are doing by saying, "I want my child to be happy." And there is no doubt that they achieve this goal. Unfortunately, whatever happiness they bring to their little one is only momentary. Moreover, it ups the ante for making their child happy the next time around. Consequently, by neglecting to remain within reasonable limits, they are virtually guaranteeing their kid will suffer a great deal of misery and dissatisfaction later on.

An area where I am already seeing the long-term effects of this trend is employment. Many personnel directors have told me that recent college graduates feel entitled to a high-paying job that comes with a cushy corner office and plenty of perks plus complete autonomy to do whatever they feel like doing. They are completely baffled when it is suggested to them that they need to pay their dues and work their way to the top, and they are subsequently devastated when it turns out that their attitude has resulted in their being denied the position they desired.

I'm also seeing mothers and fathers starting to suffer. An increasing number of young adults are choosing to return home and live with their parents after graduating from college. Even if they have found employment, they refuse to consider being on their own until they can afford all the luxuries and services they enjoyed while they were growing up. Furthermore, they fully expect Mom and Dad to continue doing things and buying things for them, and they become angry and resentful

if Mom and Dad dare to suggest it is time for them to take care of themselves.

Perhaps the best way to understand all this is to take a look at child stars. It seems that every time you pick up a tabloid or turn on the television, you see another story about a kid who starred in a successful TV series or a few blockbuster movies but now, as a young adult, has plummeted into a world full of problems that include depression, drug addiction, and sometimes suicide. After years of being rich and famous and getting everything they could possibly want and doing whatever they desired, they find it hard to deal with an ordinary life that involves a fair amount of effort, occasional frustration, and the frequent need to experience delayed or partial rather than immediate and full gratification.

What you don't see very often are stories about child stars who are doing well in adulthood. But if you do see such a story, you can bet that it features a mother and father who established an appropriate adaptation level for their kid. While it was tempting to indulge their little one's every whim and go along for the ride, they recognized their parental responsibilities and made sure that their kid grew up with a reasonable and realistic set of standards.

A while back, I watched Ron Howard being interviewed. Most people remember him as the boy Opie on *The Andy Griffith Show* and the teenager Richie on *Happy Days*. Some may recall that his little brother, Clint, also was a star on the show *Gentle Ben*. Together, these brothers enjoyed widespread adulation and amassed a not-so-small fortune during their early years.

Today, Ron enjoys a successful career as an Academy Award-winning director. He has been married to his first and only wife for decades, and they have an enjoyable and fulfilling family life. Although I do not know him personally, my impression is that he is just about the most content, well-adjusted, and accomplished person you will find in Hollywood.

In the interview, he talked about the fact that his parents never touched a single dollar of the millions that he and his brother earned as child actors. Everything went into a trust fund, and the family got by on the income their father made as a movie extra and stunt man and the frugality and ingenuity of their stay-at-home mother. They lived in a comfortable but modest house in a lower middle class suburb. While Ron and his brother always felt loved by their mother and father, they were aware that being loved meant being disciplined and denied on occasion. And while they knew they were "special" to their parents, they also learned that they were no more special than the "regular" kids

with whom they played and went to school.

In telling tales about his childhood, Ron routinely elaborated on how excited he was about his future and how eager he was to start pursuing activities that would allow him to carry out his big plans and achieve all the goals he set for himself. And I think that reveals and emphasizes the essential lesson that many modern mothers and fathers need to learn. If you want your child to be happy and satisfied in life, you don't give them everything they want. You let them have hopes and dreams.

Michael K. Meyerhoff, EdD, is executive director of The Epicenter Inc., "The Education for Parenthood Information Center," a family advisory and advocacy agency located in Lindenhurst, Illinois. He may be contacted via e-mail at epicentrinc@aol.com.

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year old with profound language delay, and his caretaker is an aging woman responsible for multiple family members, an accurate history will not be in the cards. One is then left to expect the worst, and take whatever measures necessary to rule that possibility in or out.

Tommie ended up doing very well and was discharged home to his grandmother. Of course she learned an important lesson, and hopefully so did he, but there could be no guarantees. At the very least, we suggested that all button batteries be removed from the home, or at least from the sight and grasp of Tommie, and kids like him.

John E. Monaco, MD, is board certified in both Pediatrics and Pediatric Critical Care. His new book, Moondance to Eternity, is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.

Twins...continued from page 7

Some final thoughts. From the twins' point of view, it's pretty nice to have a built-in sibling, friend and companion right from the start. Certainly you will face some jealousy issues through the years. But on the whole, having twins really is a great experience.

Twin parenting indeed can be very tiring. When you find that it all seems too much for you to handle, just think about the poor mother who has triplets.

Dr. Eden is the chairman of the Department of Pediatrics, Wyckoff Heights Medical Center, Brooklyn, New York and a Clinical Professor of Pediatrics, Weill Cornell Medical Center, New York, NY. His latest book, Positive Parenting, is now available.

Traumatic Brain Injury: Emotional Sequelae in Children and Adolescents

By Jennifer Perez, PhD, Edward A. Maitz, PhD, Joely P. Esposito, PsyD, and Steven Mandell, MD

Each year in the United States, approximately one million children are involved in accidents that result in head injury. More specifically, the incidence of traumatic brain injury (TBI) in children under age 15 is approximately 180 in 100,000. Sports-related injuries and car accidents are among the most common causes. In children five to fourteen years of age, males are twice as likely to sustain a brain injury than females. In children ages one through five, however, the ratio becomes more even. Twenty percent of children between the ages of birth and four who sustain head or brain injuries do so as a result of a motor vehicle or motor vehicle-related accidents. The percentage of brain injury due to motor vehicle accidents increases with age, and this number rises to 66% when considering adolescents. Bike-related accidents are more likely to affect younger children. Almost half of brain injuries in infants, toddlers and young children are a result of abuse, assaults and falls.

Mild traumatic brain injury (MTBI) is defined as a Glasgow Coma Scale (GSC) score of 13-15, indicating minor alterations in verbal and motor responsiveness. Loss of consciousness lasting less than 30 minutes and post-traumatic amnesia and confusion lasting less than 24 hours, are also required to be considered a MTBI. Additionally, computed tomography (CT) scans absent of contusions (bruising) or hematomas (collection of blood) can rule out more severe levels of injury. These are the minimal requirements necessary to be considered a MBTI. Anything beyond these criteria are considered moderate to severe levels of injury.

Some degree of cognitive, emotional and/or behavioral disturbance generally occurs after most traumatic brain injuries, regardless of the level of severity. The disturbances may be a direct result of the injury to the brain, may signify an increase in symptoms that were present prior to the injury, or may be a psychological/emotional reaction to injury and changes that have resulted from it. Emotional sequelae, or disturbances, are different for each child and depend on the severity and site of the injury, pre-injury functioning (personal and family), developmental stage during which injury occurred, and post-injury environment. Investigating

and understanding which of these factors apply to a particular child following a TBI is instrumental in developing effective interventions.

Emotional sequelae can include anxiety, depression, withdrawal, altered temperament, decreased initiation, and attention-seeking behaviors. Areas of impoverished behavior, such as lethargy and decreased motivation, must also be considered. Behavioral sequelae may include aggression, rage and problems maintaining self control. Emotional and behavioral sequelae may be more persistent than cognitive and physical symptoms. Additionally, it is not uncommon for the problems to worsen, rather than improve, with time.

A large proportion of children who develop depressed mood following TBI have pre-injury risk factors, such as personal history of depressed mood or a first-degree relative with a history of mood disorders. A study found new mood disorders in 16% of moderate TBI cases, and 21% of mild TBI accidents. It has also been found that TBI can increase the risk of depression, particularly in socially disadvantaged children. Children who experience depression often describe feeling hopeless, being disinterested in activities, lacking in energy and lacking in self-confidence.

It has been suggested that depression associated with TBI may have a neurologic basis. Children with an acute depression are likely to have left anterior (frontal) lesions, while patients with mixed anxiety and depression are likely to have a lesion in their right hemisphere. Additionally, children with a right hemispheric lesion are more likely to have a longer duration of depression and poorer psychosocial outcome. However, the findings are still controversial.

Significant increases in anxiety symptoms after TBI are also common. Overanxious disorders, specific phobias, separation anxiety disorders, and social anxiety disorders reflect the various types of anxiety that children often experience following brain injury. Overanxious disorders, commonly referred to as generalized anxiety disorders, refer to excessive, persistent and unrealistic worry. Specific phobias are characterized by extreme fear of objects or situations where little or no threat

is actually present. Separation anxiety disorders refer to excessive anxiety upon separation from caregivers that is beyond what is developmentally expected. Social anxiety is characterized by excessive self-consciousness and anxiety in everyday situations. While there is not any one specific anxiety disorder that is the most prevalent, some studies suggested there is a trend towards increases in overanxious disorder.

The development of behavioral disorders is very common following a TBI. In particular, oppositional defiant disorder (ODD) may occur in the first year after injury. This is typically related to pre-injury factors such as family functioning, socioeconomic status, and pre-existing ODD symptomology. On the contrary, at two years after injury, severity of injury becomes a predictor of ODD. In other words, psychosocial factors are greater predictors of ODD in the first, but not second, year after a TBI.

In school-age children the emphasis of treatment is on school and peers. Strategies commonly used include self-monitoring and reward, social-skills training, and problem-solving training. Parents and teachers must learn to break down tasks and modify expectations. Work done at home must carry over into work done at school and vice versa. Non-academic opportunities for growth, such as music, sports and creative arts, should also be encouraged.

In adolescence, hormonal changes, growth spurts, social stressors and increasing academic demands also contribute to adjustment problems in older children. Interventions used on school-age children are likely to be met with resistance and rebellion. Many children engage in inappropriate risk taking, experimentation with drugs and alcohol, and sexual promiscuity. Group interventions are useful, as they provide a way to both learn from and receive feedback from peers rather than authority figures. Groups can be targeted towards a specific medical condition (brain injury, diabetes), or targeted towards specific skills (social skills, problem solving). In some extreme cases, hospitalization may be necessary for the protection of the adolescent as well as those individuals in his or her environment. If hospitalization is required, primary focus of treatment should be vocational and independent living skills.

Research clearly suggests that family functioning prior to injury is a significant predictor of the child's outcome. Family functioning after brain injury is an important predictor as well. Family needs should be assessed immediately after injury, and periodically in the months and years following the injury. Family and educational support services should be investigated

and made available to families in need.

Prevention is the first line of action in reducing the number of children who suffer from a traumatic brain injury each year. Bicycle and motor vehicle safety educational programs should be emphasized. Additionally, programs designed to reduce the incidence of drunk driving, child abuse and neglect are also essential to protect children from traumatic brain injuries.

For more information about traumatic brain injury, please refer to the following resources:

National Institute of Neurologic Disorders and Stroke
www.ninds.nih.gov/disorders/tbi/tbi.htm

Brain Injury Association
www.biausa.org/

National Head Injury Foundation
www.threeriversinc.org

National Brain Injury Research, Treatment and Training Foundation
www.nbirtt.org/main.html

Head Trauma Support Project
www.healthatoz.com/healthatoz/Atoz/ency/head_injury.jsp

Jennifer Perez is a certified school psychologist and received her doctoral degree in Clinical Psychology from Widener University. She has a particular interest in working with children who have development disorders or who have had a traumatic brain injury.

Dr. Maitz is a Board certified neuropsychologist in private practice in Pennsylvania and in New Jersey. He has more than 30 years of experience treating patients with various neurological disorders. He has authored several professional articles and presented papers at professional conferences in the US and Canada.

PediaTrick

Tick Trick

Here's a new way to remove a tick: rub it off. According to Maureen Breese, NP, rub with one finger around the tick. The finger should be close enough to touch the tick's body. After rubbing for two to four minutes, the tick backs out of the skin.

Consultant 10/07

An Answer for Children with Type 1 Diabetes

By H. Peter Chase, MD

In the United States, about 150,000 children are affected by type 1 diabetes and 13,000 more will be diagnosed each year. To survive, patients need to control their glucose (sugar) levels by taking daily insulin injections. Alarming, however, nearly 70% of diagnosed children live with poorly controlled diabetes despite medications that control symptoms and let children live as close to a normal life as possible.

The lack of diabetes control in so many suffering children can be linked to needle fear, which is present in nearly 25% of all people, and can result in children not getting their daily insulin injections. This is especially concerning for children today because more and more complications stem from uncontrolled diabetes. But, a recent study conducted at the Barbara Davis Center for Childhood Diabetes sheds light on the issue of impact of needle fear and its importance in understanding childhood diabetes.

The study, designed to investigate the reasons for poor glycemic control in children with type 1 diabetes showed the importance of reducing pain to minimize needle anxiety when introducing daily injections. In this study, patients were divided into three different groups: a control group (insulin, NovoPen insulin delivery device and FreeStyle glucose meter), an alarm group (control group plus a Flash FreeStyle alarmable meter) and the Insuflon group (control group plus the Insuflon). Needle anxiety and glycemic control was measured at three and six months.

Two key findings came from this study. First, a link between needle fear and the pain associated with the daily injections was found as one of the main reasons for the poor control of childhood diabetes. Second, use of the Insuflon injection port reduced the needle pain associated with injections and increased therapy compliance in children with diabetes.

The Insuflon injection port is a soft catheter usually inserted in the abdomen or buttocks. Although the pain of insertion is minimal, a topical anaesthetic cream can be used to reduce anxiety. After removing the insertion needle, the port stays in the body and the insulin can be easily injected, thereby reducing the number of pricks significantly. The Insuflon helps to improve

insulin control and reduces the risk of diabetic complications. Conveniently, it can be worn while children play sports, swim and bathe. It is usually left in place for five to seven days.

Finding a simple solution to poorly controlled diabetes resulting from needle anxiety can have a significant impact. In this study, using a simple device such as the Insuflon injection port, daily insulin injections were better received by children, treatment compliance increased and glycemic control improved. Although the Insuflon port may not be the right option for everyone, the study demonstrates that it is clearly a viable alternative for people to lessen needle anxiety and for health care practitioners to set off a successful course of treatment.

Dr. Peter Chase is clinical director, emeritus at the Barbara Davis Center for Childhood Diabetes and is recognized among the top one percent of physicians in America. He has authored eleven editions of the acclaimed educational book, Understanding Insulin Dependent Diabetes, as well as over 220 research articles and 41 books or chapters.

Top Ten Reasons for Pediatric Visits

Routine child health exams	22.9%
Ear infections	6.6%
Acute Upper Respiratory Infections ..	4.6%
Acute pharyngitis	3.4%
ADD	3.2%
Asthma	2.8%
Chronic Sinusitis	2.4%
Vaccine for a bacterial disease	2.3%
Streptococcal throat	1.9%
Allergic rhinitis	1.9%

(Based on 156,981 diagnoses for visits
January-September, 2007)

Pediatric News, 12/07

Swaddling Babies for a More Restful Sleep

By Susan M. Heim

When babies have trouble sleeping, their parents do, too. And the effects of sleep deprivation can be extremely acute on one's mental and physical health. A mother may lose up to 350 hours of sleep during her baby's first year of life, resulting in irritability, added stress, and confused thinking.

Many parents have found relief for their restless infants through swaddling. In fact, the practice of swaddling – wrapping a baby's body snugly in a blanket to sleep – is not a new concept. It has been around for centuries. Many Native Americans traditionally swaddled their babies. Remember the etching of Sacajawea on the U.S. dollar coin with her baby bundled snugly on her back?

According to Dr. Harvey Karp in his book, *The Happiest Baby on the Block*, "For tens of thousands of years, mothers living in cool climates have swaddled their babies. ... History has recorded that Alexander the Great, Julius Caesar and Jesus were all swaddled as babies... And now, our nation has also rediscovered that babies like being wrapped as snug as a bug in a rug."

Swaddling is practiced widely in hospital nurseries, and parents in countries such as Albania, Turkey and Afghanistan have used traditional swaddling methods for generations. These techniques often include special swaddling clothes and bands, or several cloths positioned in a particular way to keep the baby secure.

Parents are strongly advised to place infants to sleep on their backs to reduce the risk of death from sudden infant death syndrome (SIDS), but babies in this position are often afflicted with the startle (or Moro) reflex, in which their arms and legs pop up and jerk spasmodically. Naturally, this wakes them up or prevents them from falling asleep. Exhausted parents may respond by allowing their babies to sleep on their stomachs. Instead, medical professionals recommend simulating a "fourth trimester" for infants, in which womblike conditions are re-created, reducing the likelihood of the startle reflex. Swaddling can be a very effective tool in this regard as it makes the infant feel as if it is still being held tightly in its mother's body. Studies show that parents are more likely to encourage infants to sleep on their backs when they are swaddled.

Swaddling may also make a baby feel as if it's being cuddled in its mother's arms. Research has proven that being touched is essential to babies' normal development. Further, swaddling can help to get babies on a

sleeping schedule. For some infants, the mere act of starting the swaddling process acts as a signal that it is time for bed, and their eyes begin to droop in sleep.

Researchers at University Children's Hospital, in Brussels, Belgium, concluded that, "[W]hen infants between six and 16 weeks of age sleep swaddled and supine, they sleep longer, spend more time in NREM sleep, and awake less spontaneously than when not swaddled."

If the benefits are so numerous, why don't more parents swaddle their babies? It can be a challenge to learn how to swaddle a baby properly using a standard blanket. The blanket must be tight enough to stay fastened and make the baby feel secure, and yet loose enough so that the infant doesn't become overheated. Once a baby starts moving around, he often kicks off his blanket, and a loose blanket in the crib can increase the risk of SIDS. And most receiving blankets aren't large enough to properly swaddle a growing infant after a few months or even weeks.

But a wide variety of specially made swaddling blankets designed to overcome the limitations of traditional swaddling are now available. These blankets may be structured to fit a baby's shape, long enough to wrap around his body, and might have fasteners to prevent an infant from pulling the swaddle loose.

Some parents give up swaddling too quickly because their babies don't seem to like it, but parents who have swaddled successfully report that it doesn't take long before most babies realize they love it. True, some babies will never grow accustomed to swaddling, but the vast majority sleep better as a result of being swaddled. If your baby resists swaddling at first, Dr. Karp advises, "Be patient. You may have to practice a few times before [the baby] gets used to it. Try swaddling when she's already sleepy and in her most receptive frame of mind."

The results of swaddling are likely to be a better-sleeping baby – and more well-rested parents. Proven effective over centuries of parenting and research, swaddling is a practice that really works.

Susan M. Heim is a writer and editor, specializing in parenting and women's issues, and is a former Senior Editor for the bestselling Chicken Soup for the Soul series. She has written a number of books and many articles. She writes a regular online column for Mommies Magazine called "Loving and Living with Twins and Multiples."

Your Questions Answered

Roy Benaroch, MD, answers your questions this month. He practices in Atlanta, GA. and is a frequent contributor to the newsletter and the Pediatrics for Parents podcast. Sharon Fried Buchalter, Ph.D., is a distinguished clinical psychologist, family/marriage therapist, relationship expert and author.

Send your questions to QandA@pedsforparents.com or Pediatrics for Parents, PO Box 219, Gloucester, MA 01931. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such questions should be asked of your child's doctor.

Stomach Sleeping

Q My daughter is six weeks and two days old and will not sleep on her back. I have been putting her on her stomach to sleep and notice that it is the only way she will sleep. What do you suggest I do? I know babies shouldn't sleep on their stomach but that is the only way my daughter will sleep. My son, who is now 3 years old, was the same way.

A Putting babies down to sleep on their backs is a very effective way to prevent Sudden Infant Death Syndrome (SIDS). Unless there are very specific medical reasons not to, all babies should always be put down to sleep on their backs.

However, you've got a different problem now. At six weeks of age, your baby will have hard time learning to sleep well on her back. Back sleeping should be started as soon as baby is born. Babies who are placed with a good swaddle on their backs as newborns will sleep just as well as babies on their tummies, but you do have to start this habit early.

It is also especially dangerous for babies who usually sleep on their backs to occasionally sleep on their tummies. Babies should always, for naps and night-sleep, be put down on their backs. Note that this doesn't mean they have to stay on their backs – once baby can roll to her tummy, leave her there. Don't use any devices or wedges to force a baby to stay on her back.

There are other important ways to prevent SIDS. Do not smoke cigarettes during or after the pregnancy, and do not allow anyone near the baby to smoke. Don't overbundle, and don't keep the room especially warm. There is good evidence that the safest place for a baby to sleep is in the parents' room, but in a separate crib or bassinet – not in the parents' bed. It is especially dangerous for parents who are overweight or who are taking sedating medications or alcohol to bed-share. Bedding should not be overly soft. You should not rely on devices or alarms to help protect your baby, as there is no evidence that any of these work.

I understand that you are in a difficult situation, as

your baby has learned to sleep better on her tummy. The safest thing to do is swaddle her, put her down on her back, and give her a chance to learn to sleep that way. There will be crying. If you don't think you can put up with the crying and fussing, you will be taking some extra risk by continuing to tummy sleep.

Roy Benaroch, MD

Thumb Sucking

Q My three-year-old still sucks his thumb. We were hoping that once he was in preschool he would stop doing it, but that isn't the case. How can we get him to stop sucking his thumb?

A Thumb sucking is one of the five most common habits among children. Most thumb suckers are younger children, between the ages of two and four years old. Many children suck their thumbs to calm and comfort themselves. The most common time for thumb sucking is when children are tired, bored, or in need of comfort.

Unlike other habits, like nail biting, most children outgrow thumb sucking. Pressure applied against thumb sucking may turn a natural developmental phase into an ingrained habit. Instead, you should try to create an environment where your child chooses to stop on his own. You can create this environment by providing unconditional love and support and not forcing your child to stop the habit. If your child decides on his own to stop but is having trouble doing so, then you can help him notice when he is doing it.

Without nagging or arguing, almost all children stop before age four or five. For the very few that don't, the dentist or doctor can help. Explain the situation to your child's doctor or dentist. The dentist can explain to your child about how sucking his thumb can make his teeth crooked and can give him infections or boo-boos in his mouth. The child's doctor can explain that there are germs on hands and by sucking his thumb, your child can get sick or get sores in his mouth.

Sharon Fried Buchalter, PhD

Calcium and Children's Bone Health

By Tania Winzenberg, FRACGP, PhD, Graeme Jones, FRCP, MD, and Kelly Shaw, FRACGP, PhD, FAFPHM

Osteoporosis is a condition in which people lose bone-mass and their bones become weaker, resulting in more frequent fractures. Osteoporosis is commonly thought of as a disease of the elderly and particularly of women, but men are also at risk of osteoporosis as they grow older. Fractures in the elderly are common – about 1 in 2 women and 1 in 4 men over 60 years of age will fracture a bone due to osteoporosis.

Preventing osteoporosis in later life actually starts in childhood; it is as important to ensure good bone health in childhood as it is to slow the bone loss that occurs as we grow older. The maximum amount of bone attained in childhood is called peak bone mass. It is estimated that if we could increase peak bone mass by 10%, we could delay the onset of osteoporosis by about 13 years! About 90% of peak bone mass is reached by age 18, so ensuring growth of bone is maximized in childhood is very important to our future bone health. If children have low bone density (a measure of the amount of bone they have), they are more at risk of fracture, too. So improving bone health in children could help prevent childhood fractures.

Calcium is a major component of the mineral that forms bone, and adequate calcium levels are important to bone health. However, encouraging children to increase their calcium intake through diet can be difficult, and managing to get children to take calcium supplements is also very challenging. So, if we are going to put our efforts into improving children's calcium intake, how much benefit are we likely to get?

There are a large number of studies in which children have been given calcium supplements to see if their bone density improves. We undertook a summary of all these studies to see how much benefit healthy children might obtain from taking a regular calcium supplement. We found that calcium supplements had no effect on bone density at the hip or spine, which are two of the most important sites of serious fracture in later life. While calcium supplements did cause a small increase in the total amount of bone mineral overall in the body, once children stopped using supplements, the effect disappeared. In the forearm, there was a small increase in bone density, but it was too small to be likely to reduce fractures either in childhood or in later life. It did not matter how long supplements were taken for, the effects stayed the same. There was no

evidence to suggest that children with calcium intakes as low as 600 mg per day had any greater benefit than children with diets high in calcium. Other studies that gave children dairy products rather than calcium supplements had similar results.

These results mean that, in general, adding calcium supplements to the diet of healthy children is unlikely to benefit their bone health and is not recommended in most children. Some children have very low calcium intakes (< 600 mg per day), for example if they do not take any dairy in the diet. Encouraging alternative sources of calcium intake in the diet or from supplements may be still worth considering in this case. If your child has a medical condition or takes medication likely to have a negative effect on their bone, calcium supplementation also might still be recommended by your health professional.

Other lifestyle factors besides calcium intake can influence children's bone development, though this is an area that requires more research. These factors include:

- Weight-bearing physical activity, particularly activities involving running and jumping
- Ensuring adequate levels of vitamin D from a mixture of diet, sun exposure and vitamin D supplements;
- Adequate fruit and vegetable intake, and;
- Low salt intake

These factors are important for good health generally and for the prevention of other common diseases. Taking a balanced approach to improving your child's bone health through a balanced, healthy lifestyle is likely to give the best long-term health outcome overall.

Dr Tania Winzenberg is a family physician who completed a Master of Medical Science in Clinical Epidemiology from the University of Newcastle before moving into a research position at the Menzies Research Institute in Hobart, Tasmania, Australia in mid-2002. She was awarded her PhD in 2006 for work in the area of promoting lifestyle change for osteoporosis prevention in young women and children. Currently, she is developing a research program in primary health care area, addressing chronic diseases prevention and management, particularly for musculoskeletal conditions.

A Few Words from the Editor

This issue marks the beginning of the 28th year of *Pediatrics for Parents*. It's hard for me to believe that I have been publishing *Pediatrics for Parents* for that long.

The newsletter began when I was a second-year family practice resident at the Eastern Maine Medical Center, Bangor, ME; its inception grew out of two revelations.

First, I realized the importance of patient education. Well-informed patients better understand their illness and become active partners in their healthcare. Second, I saw that I could reach – and educate – a lot more people with a newsletter than with my access to a limited number of patients I saw each day.

There have been some slow times with *Pediatrics for Parents* when the issues were few and far between. Now I publish 12 issues a year, have numerous medical and professional contributors, and send the newsletter to over 140,000 readers.

You, the readers, have always been an important part of the newsletter. Your input continues to be important. I take your comments, suggestions, and criticisms seriously, and I encourage you to contact me. So keep on letting me know what you think about *Pediatrics for Parents*.

I hope you continue to enjoy *Pediatrics for Parents* for many years to come.

–Rich Sagall, MD

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